FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032169

Facility Name: SHABBONA HEALTHCARE CENTER

Address: 409 W. COMMANCHE STREET (Number) SHABBONA (City) 60550 (Zip Code)

County: DEKALB

Telephone Number: (815) 824-2194 **Fax #** (815) 824-2188

IDPA ID Number: 363503389001

Date of Initial License for Current Owners: 04/01/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) NOSHIR R. DARUWALLA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	91	Skilled (SNF)	91	33,215	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	91	TOTALS	91	33,215	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,917	4,431	1,738	8,086	8
9	SNF/PED					9
10	ICF	8,460	5,651		14,111	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,377	10,082	1,738	22,197	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.83%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NA

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1,679

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	140,829	7,529	6,690	155,048		155,048	(160)	154,888			1
2	Food Purchase		116,990		116,990		116,990	(531)	116,459			2
3	Housekeeping	183,163	66,206		249,369		249,369		249,369			3
4	Laundry	65,164	4,469		69,633		69,633		69,633			4
5	Heat and Other Utilities			85,157	85,157		85,157	1,343	86,500			5
6	Maintenance	49,404	32,174	7,148	88,726		88,726	629	89,355			6
7	Other (specify):*											7
8	**TOTAL General Services**	438,560	227,368	98,995	764,923		764,923	1,281	766,204			8
	B. Health Care and Programs											
9	Medical Director			200	200		200		200			9
10	Nursing and Medical Records	965,847	11,418	2,108	979,373		979,373	(133)	979,240			10
10a	Therapy	100			100		100		100			10a
11	Activities	60,606	7,281		67,887		67,887		67,887			11
12	Social Services	39,512		7,293	46,805		46,805		46,805			12
13	Nurse Aide Training			1,295	1,295		1,295		1,295			13
14	Program Transportation			626	626		626		626			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,066,065	18,699	11,522	1,096,286		1,096,286	(133)	1,096,153			16
	C. General Administration											
17	Administrative	55,036		138,300	193,336		193,336	(37,345)	155,991			17
18	Directors Fees											18
19	Professional Services			25,675	25,675		25,675	4,307	29,982			19
20	Dues, Fees, Subscriptions & Promotions			42,497	42,497		42,497	(14,070)	28,427			20
21	Clerical & General Office Expenses	140,256	1,869	43,892	186,017		186,017	34,410	220,427			21
22	Employee Benefits & Payroll Taxes			241,616	241,616		241,616		241,616			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,640	2,640		2,640	52	2,692			24
25	Other Admin. Staff Transportation			5,232	5,232		5,232	1,063	6,295			25
26	Insurance-Prop.Liab.Malpractice			23,298	23,298		23,298	1,374	24,672			26
27	Other (specify):*							10,536	10,536			27
28	**TOTAL General Administration**	195,292	1,869	523,150	720,311		720,311	327	720,638			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,699,917	247,936	633,667	2,581,520		2,581,520	1,474	2,582,994			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER #0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			22,692	22,692		22,692	78,164	100,856			30
31	Amortization of Pre-Op. & Org.							2,921	2,921			31
32	Interest			59,960	59,960		59,960	92,293	152,253			32
33	Real Estate Taxes			39,618	39,618		39,618	2,149	41,767			33
34	Rent-Facility & Grounds			298,935	298,935		298,935	(298,935)				34
35	Rent-Equipment & Vehicles							758	758			35
36	Other (specify):*											36
37	**TOTAL Ownership**			421,205	421,205		421,205	(122,650)	298,555			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,096	44,925	102,021		102,021	(275)	101,746			39
40	Barber and Beauty Shops			4,355	4,355		4,355	(4,006)	349			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,823	49,823		49,823		49,823			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		57,096	99,103	156,199		156,199	(4,281)	151,918			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,699,917	305,032	1,153,975	3,158,924		3,158,924	(125,457)	3,033,467			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,749	30		9
10	Interest and Other Investment Income	(4,922)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(531)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(28)	21		18
19	Entertainment				19
20	Contributions	(2,050)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,408)	21		24
25	Fund Raising, Advertising and Promotional	(10,240)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(348)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,563)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (22,341)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(103,116)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (103,116)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (125,457)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SHABBONA HEALTHCARE CENTER

ID# 0032169

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PRIOR YEAR LEGAL EXPENSES	$ (2,819)	19	1
2	ILLINOIS COUNCIL LTC - COPE	(1,824)	20	2
3	VETERANS EXPENSE PHARMACY	(133)	10	3
4	THEFT & DAMAGE LOSS	(1,500)	21	4
5	TRUST FEES	(150)	21	5
6	R.O. REPLACEMENT TAX	(131)	21	6
7	BARBER & BEAUTY INCOME	(4,006)	40	7
8				8
9				9
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(160)							(160)	1
2	Food Purchase	(531)											(531)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,343									1,343	5
6	Maintenance			629									629	6
7	Other (specify):*													7
8	**TOTAL General Services**	(531)		1,972		(160)							1,281	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(133)											(133)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(133)											(133)	16
	C. General Administration													
17	Administrative			(37,345)									(37,345)	17
18	Directors Fees													18
19	Professional Services	(2,819)		640	6,485								4,307	19
20	Fees, Subscriptions & Promotions	(14,114)		44									(14,070)	20
21	Clerical & General Office Expenses	(4,565)	131	38,844									34,410	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			52									52	24
25	Other Admin. Staff Transportation			1,063									1,063	25
26	Insurance-Prop.Liab.Malpractice			1,374									1,374	26
27	Other (specify):*			10,536									10,536	27
28	**TOTAL General Administration**	(21,498)	131	15,208	6,485								327	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(22,162)	131	17,180	6,485	(160)							1,474	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	8,749	67,784	1,631									78,164	30
31	Amortization of Pre-Op. & Org.		2,921										2,921	31
32	Interest	(4,922)	210,700	1,723	(115,208)								92,293	32
33	Real Estate Taxes			2,149									2,149	33
34	Rent-Facility & Grounds		(298,935)										(298,935)	34
35	Rent-Equipment & Vehicles			758									758	35
36	Other (specify):*													36
37	TOTAL Ownership	3,827	(17,530)	6,261	(115,208)								(122,650)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(275)							(275)	39
40	Barber and Beauty Shops	(4,006)											(4,006)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(4,006)				(275)							(4,281)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(22,341)	(17,399)	23,441	(108,723)	(435)							(125,457)	45

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SHELDON WOLFE	50.00 %	SEE ATTACHED		SEE ATTACHED		
ALBERT MILSTEIN	50.00 %	SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 298,935	SHABBONA BUILDING ASSOC. LLC		$	$ (298,935)	1
2	V	32	INTEREST EXPENSE		SHABBONA BUILDING ASSOC. LLC		262,539	262,539	2
3	V	30	DEPRECIATION		SHABBONA BUILDING ASSOC. LLC		67,784	67,784	3
4	V	31	AMORTIZATION		SHABBONA BUILDING ASSOC. LLC		2,921	2,921	4
5	V	21	REPLACEMENT TAX		SHABBONA BUILDING ASSOC. LLC		131	131	5
6	V	32	INTEREST EXPENSE	51,672	SHABBONA BUILDING ASSOC. LLC			(51,672)	6
7	V	32	GAIN IN PARTNERSHIP	167	SHABBONA BUILDING ASSOC. LLC			(167)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 350,774			$ 333,375	$ * (17,399)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.W. MANAGEMENT	100.00%	$ 1,343	$ 1,343	15
16	V	6	REPAIRS AND MAINT.		S.W. MANAGEMENT		629	629	16
17	V	19	PROFESSIONAL FEES		S.W. MANAGEMENT		640	640	17
18	V	20	FEES, SUBSCRIPTIONS, DUES		S.W. MANAGEMENT		44	44	18
19	V	21	CLERICAL AND GENERAL		S.W. MANAGEMENT		38,844	38,844	19
20	V	24	EDUCATION AND SEMINARS		S.W. MANAGEMENT		52	52	20
21	V	25	TRANSPORTATION		S.W. MANAGEMENT		1,063	1,063	21
22	V	26	INSURANCE - PROPERTY		S.W. MANAGEMENT		1,374	1,374	22
23	V	27	PAYROLL TAXES		S.W. MANAGEMENT		6,777	6,777	23
24	V	30	DEPRECIATION		S.W. MANAGEMENT		1,631	1,631	24
25	V	32	INTEREST EXPENSE		S.W. MANAGEMENT		1,723	1,723	25
26	V	33	REAL ESTATE TAXES		S.W. MANAGEMENT		2,149	2,149	26
27	V	35	AUTO LEASE		S.W. MANAGEMENT		758	758	27
28	V								28
29	V								29
30	V	17	SALARY - SHELDON WOLFE		SW. MANAGEMENT		100,955	100,955	30
31	V	17	SALARY - RONNIE KLEIN		SW. MANAGEMENT				31
32	V	27	EMP. BEN.-SHELDON WOLFE		SW. MANAGEMENT		3,759	3,759	32
33	V	27	EMP. BEN.-RONNIE KLEIN		SW. MANAGEMENT				33
34	V								34
35	V	17	MANAGEMENT FEES	72,000	SW. MANAGEMENT			(72,000)	35
36	V	17	HOME OFFICE FEES	66,300	SW. MANAGEMENT			(66,300)	36
37	V								37
38	V								38
39	Total			$ 138,300			$ 161,741	$ * 23,441	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	SFO ASSOCIATES	100.00%	$ 6,485	$ 6,485	15
16	V	32	INTEREST		SFO ASSOCIATES		146,886	146,886	16
17	V								17
18	V								18
19	V								19
20	V	32	INTEREST	262,094	SFO ASSOCIATES			(262,094)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 262,094			$ 153,371	$ * (108,723)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SUPPLEMENTS	$ 1,600	S & E MEDICAL SUPPLY	100.00%	$ 1,440	$ (160)	15
16	V	39	ANICILLARY EXPENSE	1,375	S & E MEDICAL SUPPLY	100.00%	1,100	(275)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,975			$ 2,540	$ * (435)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING & MEDICAL SUPPLY	$ 3,635	PHARMCOR, L.L.C.	100.00%	$ 3,635	$	15
16	V	39	ANICILLARY EXPENSE	52,180	PHARMCOR, L.L.C.	100.00%	52,180		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 55,815			$ 55,815	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHELDON WOLFE	PRESIDENT	ADMN	50.00%	SEE ATTACHED	9	15.00%	SW MGMT	$ 100,955	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 100,955		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.W. MANAGEMENT
Street Address: 7434 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIABLE BED DAYS	450,410	8	$ 18,206	$	33,215	$ 1,343	1
2	6	REPAIRS AND MAINT.	AVAIABLE BED DAYS	450,410	8	8,532		33,215	629	2
3	19	PROFESSIONAL FEES	AVAIABLE BED DAYS	450,410	8	8,672		33,215	640	3
4	20	FEES, SUBSCRIPTIONS, DUES	AVAIABLE BED DAYS	450,410	8	603		33,215	44	4
5	21	CLERICAL AND GENERAL	AVAIABLE BED DAYS	450,410	8	526,738	470,813	33,215	38,844	5
6	24	EDUCATION AND SEMINARS	AVAIABLE BED DAYS	450,410	8	710		33,215	52	6
7	25	TRANSPORTATION	AVAIABLE BED DAYS	450,410	8	14,421		33,215	1,063	7
8	26	INSURANCE - PROPERTY	AVAIABLE BED DAYS	450,410	8	18,629		33,215	1,374	8
9	27	PAYROLL TAXES	AVAIABLE BED DAYS	450,410	8	91,903		33,215	6,777	9
10	30	DEPRECIATION	AVAIABLE BED DAYS	450,410	8	22,118		33,215	1,631	10
11	32	INTEREST EXPENSE	AVAIABLE BED DAYS	450,410	8	23,361		33,215	1,723	11
12	33	REAL ESTATE TAXES	AVAIABLE BED DAYS	450,410	8	29,144		33,215	2,149	12
13	35	AUTO LEASE	AVAIABLE BED DAYS	450,410	8	10,285		33,215	758	13
14										14
15										15
16	17	SALARY - SHELDON WOLFE	AVG. HOURS WORKED	60	9	673,036	673,036	9	100,955	16
17	17	SALARY - RONNIE KLEIN	AVG. HOURS WORKED	60	7	60,000	60,000			17
18	27	EMP. BEN.-SHELDON WOLFE	AVG. HOURS WORKED	60	9	25,062		9	3,759	18
19	27	EMP. BEN.-RONNIE KLEIN	AVG. HOURS WORKED	60	7	8,356				19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,539,776	$ 1,203,849		$ 161,741	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SFO ASSOCIATES
Street Address: 7434 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	NOTE RECEIVABLE	6,500,000	3	$ 24,796	$	1,700,000	$ 6,485	1
2	32	INTEREST	NOTE RECEIVABLE	6,500,000	3	561,623		1,700,000	146,886	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 586,419	$		$ 153,371	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S & E MEDICAL SUPPLY
Street Address: 3100 COMMERCIAL AVENUE
City / State / Zip Code: NORTHBROOK, ILLINOIS 60062
Phone Number: (847) 982-9300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SUPPLEMENTS	DIRECT ALLOCATION						1,440	1
2	39	ANICILLARY EXPENSE	DIRECT ALLOCATION						1,100	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,540	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PHARMCOR, L.L.C.
Street Address: 3116 S. OAK PARK
City / State / Zip Code: BERWYN, IL 60402
Phone Number: (708)795-7701
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION						3,635	1
2	39	ANICILLARY EXPENSE	DIRECT ALLOCATION						52,180	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 55,815	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	N/P SFO ASSOCIATES	X					$	$ 1,307,692			$	1
2	DUE TO/FROM SHABB LLC	X									59,960	2
3	N/P AUTO		X					32,579				3
4												4
5												5
	Working Capital											
6	DUE TO/FROM SFO ASSOC	X						1,951,647				6
7	ST LOAN EXCHANGE		X					307,333				7
8												8
9	TOTAL Facility Related						$	$ 3,599,251			$ 59,960	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										92,293	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 92,293	14
15	TOTALS (line 9+line14)						$	$ 3,599,251			$ 152,253	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST SHABBONA LLC	X					$	$			$ 262,539	1
2	INT. INCOME SHABB LLC	X									(51,672)	2
3	GAIN IN PARTNERSHIP	X									(167)	3
4	INTEREST EXP. SFO ASSOC.	X									146,886	4
5	INTEREST INC. SFO ASSOC.	X									(262,094)	5
6	INTEREST EXP. SW MGMT	X									1,723	6
7	INTEREST INC. SHABBONA										(4,922)	7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 92,293	21

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	40,134	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	41,053	2
3. Under or (over) accrual (line 2 minus line 1).	$	919	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	40,848	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	41,767	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	31,343	8
	1997	34,597	9
	1998	34,503	10
	1999	38,223	11
	2000	38,904	12

2001 ACCRUAL = $38904 X 1.05 = $40,848

ALLOCATION FROM SW MGMT = $2,149

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SHABBONA HEALTHCARE CENTER COUNTY DEKALB

FACILITY IDPH LICENSE NUMBER 0032169

CONTACT PERSON REGARDING THIS REPORT STEVE LAVANDA

TELEPHONE 815-824-2194 FAX #: 815-824-2188

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-15-327-010	Long-Term Care Property	$ 38,904.00	$ 38,904.00
2.	10-28-412-049-0000	Alloc. S.W. Mgmt	$ 29,143.61	$ 2,149.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 68,047.61	$ 41,053.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,200 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: SHABBONA LLC = $87,616
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 2,921
4. Dates Incurred: _____

Nature of Costs: LOAN COSTS
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SHABBONA ASSOC.			$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	2,650		20	177	177	2,286	9
10	Various			1990	65,810		20	3,290	3,290	38,130	10
11	Various			1991	20,535		20	1,027	1,027	12,244	11
12	Various			1992	5,466		20	273	(273)	3,644	12
13	Various			1993	13,848		20	685	685	5,744	13
14	Various			1994	39,334		20	1,967	1,967	15,309	14
15	Various			1995	13,479		20	674	674	5,410	15
16	Various			1996	11,533		20	577	577	4,043	16
17	Various			1997	18,996		20	950	950	4,563	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,682,668	68,898		69,103	205	513,733	68
69	Financial Statement Depreciation			22,693			(22,693)		69
70	TOTAL (lines 4 thru 69)		$ 2,874,319	$ 91,591		$ 78,723	$ (13,414)	$ 605,106	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,874,319	$ 91,591		$ 78,723	$ (12,868)	$ 605,106	1
2	REMODELING DINING RM	1998	2,550		20	128	128	416	2
3	REMODELING 10 ROOMS	1998			20				3
4	9 ROOM-SOUTH WING	1998			20				4
5	12 ROOMS-SOUTH WING	1998			20				5
6	16 ROOMS -NORTH WING	1998			20				6
7	HI GRADE PAINTS	1998	916		20	46	46	176	7
8	REMODELING-NORTH WIN	1998	29,331		20	1,467	1,467	5,624	8
9	REMODELING	1998	8,699		20	435	435	1,704	9
10	HI GRADE PAINTS	1998	2,369		20	118	118	472	10
11	CURTAINS	1998	1,800		20	90	90	338	11
12	LINING FOR DRAPES	1998	659		20	33	33	132	12
13	WATER MAIN	1998	934		20	47	47	188	13
14	9 ROOM-S WING-ADJ	1998	14,826		20	741	741	2,860	14
15	12 ROOMS-S WING- ADJ	1998	18,456		20	923	923	3,404	15
16	16 ROOMS -N WING-ADJ	1998	39,758		20	1,988	1,988	7,654	16
17	REMODEL 10 ROOMS-ADJ	1998	21,366		20	1,068	1,068	4,206	17
18	CONCRETE	1999	2,415		20	121	121	323	18
19	A/R HANDLER	2000	1,150		20	115	115	192	19
20	A/R HANDLER	2000	1,870		20	187	187	296	20
21	A/R HANDLER	2000	1,900		20	190	190	285	21
22	DRIVEWAY	2001	3,040		20	38	38	38	22
23	AIR HANDLER	2001	1,350		20	101	101	101	23
24	SECURITY SYSTEM	2001	1,507		20	50	50	50	24
25	TELEPHONE SYSTEM	2001	1,928		20	80	80	80	25
26	NURSE CALL SYSTEM	2001	2,745		20	138	138	138	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,033,888	$ 91,591		$ 86,827	$ (4,764)	$ 633,783	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,033,888	$ 91,591		$ 86,827	$ (4,764)	$ 633,783	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,033,888	$ 91,591		$ 86,827	$ (4,764)	$ 633,783	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,033,888	$ 91,591		$ 86,827	$ (4,764)	$ 633,783	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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18									18
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,033,888	$ 91,591		$ 86,827	$ (4,764)	$ 633,783	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,033,888	$ 91,591		$ 86,827	$ (4,764)	$ 633,783	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,033,888	$ 91,591		$ 86,827	$ (4,764)	$ 633,783	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,033,888	$ 91,591		$ 86,827	$ (4,764)	$ 633,783	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,033,888	$ 91,591		$ 86,827	$ (4,764)	$ 633,783	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,033,888	$ 91,591		$ 86,827	$ (4,764)	$ 633,783	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,033,888	$ 91,591		$ 86,827	$ (4,764)	$ 633,783	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,033,888	$ 91,591		$ 86,827	$ (4,764)	$ 633,783	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,033,888	$ 91,591		$ 86,827	$ (4,764)	$ 633,783	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,033,888	$ 91,591		$ 86,827	$ (4,764)	$ 633,783	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,033,888	$ 91,591		$ 86,827	$ (4,764)	$ 633,783	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	91		1994		$ 2,643,587	$ 67,784	39	$ 67,784	$	$ 505,634	4
5											5
6			1995		31,998	820		914	94	6,084	6
7											7
8											8
	Improvement Type**										
9											9
10	ALLOCATION SW MANAGEMENT			1995	3,405	176	20	203	27	1,307	10
11	ALLOCATION SW MANAGEMENT			1996	595	15	20	30	15	165	11
12	ALLOCATION SW MANAGEMENT			1997	856	46	20	61	(15)	261	12
13	ALLOCATION SW MANAGEMENT			1998	590	15	20	29	14	111	13
14	ALLOCATION SW MANAGEMENT			1999	1,637	42	20	82	40	171	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,682,668	$ 68,898		$ 69,103	$ 175	$ 513,733	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 102,750	$ 137	$ 10,424	$ 10,287	10	$ 68,153	71
72	Current Year Purchases	18,283	379	545	166	10	545	72
73	Fully Depreciated Assets	238,020				10	238,020	73
74								74
75	TOTALS	$ 359,053	$ 516	$ 10,969	$ 10,453		$ 306,718	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY BUSINESS	98 OLDSMOBILE	1995	$ 21,506	$	$	$	5	$ 20,982	76
77	FACILITY BUSINESS	2001 GRAND JEEP	2001	33,668		3,060	3,060	5	3,060	77
78										78
79										79
80	TOTALS			$ 55,174	$	$ 3,060	$ 3,060		$ 24,042	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,498,115	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 92,107	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 100,856	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,749	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 964,543	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ N/A NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation SW MGMT		$	$ 758	17
18					18
19					19
20					20
21	TOTAL		$	$ 758	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 1,121	$	$ 1,121
2	Books and Supplies		124		124
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		50		50
9	TOTALS	$	$ 1,295	$	$ 1,295
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,295			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 18,869	$		$ 18,869	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			449			449	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			25,607			25,607	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				52,180		52,180	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						4,916		4,916	13
14	TOTAL			$		$ 44,925	$ 57,096		$ 102,021	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 73,312	$ 73,312	1
2	Cash-Patient Deposits	341	341	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	670,462	670,462	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		27,812	5
6	Prepaid Insurance	48,775	48,775	6
7	Other Prepaid Expenses	3,659	3,659	7
8	Accounts Receivable (owners or related parties)	93,417	93,417	8
9	Other(specify): See supplemental schedule	6,654	6,654	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 896,620	$ 924,432	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		2,643,587	14
15	Leasehold Improvements, at Historical Cost	317,103	317,103	15
16	Equipment, at Historical Cost	230,410	439,710	16
17	Accumulated Depreciation (book methods)	(241,962)	(956,896)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		87,616	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(21,965)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 305,551	$ 2,559,155	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,202,171	$ 3,483,587	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 136,163	$ 136,163	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	943	943	28
29	Short-Term Notes Payable	1,017,654	1,615,025	29
30	Accrued Salaries Payable	41,814	41,814	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,627	5,627	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,848	40,848	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,243,049	$ 1,840,420	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	32,579	1,984,226	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 32,579	$ 1,984,226	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,275,628	$ 3,824,646	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (73,457)	$ (341,059)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,202,171	$ 3,483,587	48

*(See instructions.)

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 329,538	1
2	Restatements (describe):		2
3	PY Restatement of Depreciation	1,000	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 330,538	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(403,995)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (403,995)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (73,457)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,710,774	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,710,774	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,787	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,787	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,006	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,562	19
20	Radiology and X-Ray		20
21	Other Medical Services	13,764	21
22	Laundry	6,114	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 33,446	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,922	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,922	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,754,929	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	764,923	31
32	Health Care	1,096,286	32
33	General Administration	720,311	33
	B. Capital Expense		
34	Ownership	421,205	34
	C. Ancillary Expense		
35	Special Cost Centers	106,376	35
36	Provider Participation Fee	49,823	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,158,924	40
41	**Income before Income Taxes (line 30 minus line 40)****	(403,995)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (403,995)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,961	2,212	$ 48,647	$ 21.99	1
2	Assistant Director of Nursing	152	194	3,519	18.14	2
3	Registered Nurses	8,898	10,232	203,152	19.85	3
4	Licensed Practical Nurses	7,315	8,097	143,635	17.74	4
5	Nurse Aides & Orderlies	39,226	51,432	566,894	11.02	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7	8	100	12.50	8
9	Activity Director					9
10	Activity Assistants	4,354	4,816	60,606	12.58	10
11	Social Service Workers	2,693	3,009	39,512	13.13	11
12	Dietician					12
13	Food Service Supervisor	2,391	2,499	29,289	11.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,712	14,961	111,540	7.46	15
16	Dishwashers					16
17	Maintenance Workers	4,401	4,436	49,404	11.14	17
18	Housekeepers	20,520	23,132	183,163	7.92	18
19	Laundry	8,945	9,441	65,164	6.90	19
20	Administrator	2,120	2,240	55,036	24.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,746	8,698	140,256	16.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	124,441	145,407	$ 1,699,917 *	$ 11.69	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	103	$ 6,690	01-03	35
36	Medical Director	2	200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	67	1,658	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	292	7,293	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	464	$ 15,841		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	36	450	10-03	52
53	TOTAL (lines 50 - 52)	36	$ 450		53

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDY ICKES-1.1.-4.30.01	ADMINISTRATOR		$ 21,230
DONNA BIERNACKI 5.1.-12.31.01	ADMINISTRATOR		33,806
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,036

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 72,000
SW MGMT FEES	66,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 138,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
WINSTON & STRAWN	LEGAL	$ 4,766
FR&R	ACCOUNTING	20,909
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 25,675

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,973
Unemployment Compensation Insurance	13,815
FICA Taxes	129,628
Employee Health Insurance	63,590
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	2,062
Misc. Employee Benefits	100
Life Insurance	(552)
TOTAL (agree to Schedule V, line 22, col.8)	$ 241,616

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	25,386
Health Care Worker Background Check	
(Indicate # of checks performed 4)	48
Illinois Council on LTC	1,548
Advertising - Promotion	10,240
Dues & Subscriptions	751
Licenses	650
Alloc. S.W. Mgmt	44
Less: Public Relations Expense	(10,240)
Non-allowable advertising	
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,427

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,640
Alloc. S.W. Mgmt	52
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,692

**See instructions.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILL.COUNCIL ON LTC - $3,372

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ NONE Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 49,823
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ NO
c. What percent of all travel expense relates to transportation of nurses and patients? 100%ln14
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees